DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 4 — 0 0 6

2. STATE: IDAHO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

FILE COPY

4. PROPOSED EFFECTIVE DATE
February 4, 1994

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
"Hyde Amendment"

7. FEDERAL BUDGET IMPACT:
a. FFY 1994 $ - 9,000
b. FFY 1995 $ -12,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1A 1.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1 A 1.

10. SUBJECT OF AMENDMENT:
Changes required by revision of the "Hyde Amendment".

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
JERRY L. HARRIS

14. TITLE:
Director

15. DATE SUBMITTED:
March 31, 1994

16. RETURN TO:
Idaho Department of Health and Welfare
Division of Welfare
Bureau of Medicaid Policy and Reimbursement
Towers Building - 2nd Floor
P. O. Box 83720
Boise, ID 83720-0036

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: APR - 4 1994

18. DATE APPROVED: AUG 16 2001

PLAN APPROVED - ONE COPY ATTACHED AUG 16 2001

19. EFFECTIVE DATE OF APPROVED MATERIAL: FEB - 4 1994

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME:
Teresa L. Trimble

22. TITLE: ASSOCIATE REGIONAL [illegible]
DIVISION OF MEDICAL AND CHILD BENEFITS

23. REMARKS:

"POSTMARKED: 3/31/94 (DATE)" Boise ID (CITY/STATE)

FORM HCFA-179 (07-92)

Instructions on Back

3.1-A Amount, duration and scope of medical and remedial care and services provided:

1. Inpatient Hospital Services: Necessary inpatient hospital care is limited to forty (40) days of hospital care until July 1, 1987. Subsequent to July 1, 1987, no limitation is placed on the number of inpatient hospital days. However, such inpatient services must be medically necessary as determined by the Department or its authorized agent. Payment is limited to semiprivate room accommodations unless private accommodations are medically necessary and ordered by the physician.

   Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

   Excluded Services: Elective medical and surgical treatments, except family planning services and non-medically necessary cosmetic surgery, are excluded from Medicaid payment unless prior approved by the Department. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and are excluded by Medicare program are excluded from Medicaid payment.

   The Department excludes from payment: gastric stapling procedures, panniculectomy procedures, intestinal bypass surgery for the treatment of obesity, and all medical procedures for the treatment of obesity. Acupuncture, bio-feedback therapy, and laetrile therapy are excluded from payment.

   Procedures, counseling, and testing for the inducement of fertility are excluded from Medicaid payment.

   Lung transplants, pancreas transplants, multiple organ transplants, and other transplants considered investigative or experimental procedures under Medicare criteria are excluded from Medicaid payment. Only Medicare certified transplant facilities may perform organ transplants.

   The treatment of complications, consequences or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless the resulting condition is life threatening as determined by the Medicaid Policy section of the Department is excluded from Medicaid payment.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21) are excluded from Medicaid payment.

Abortion Services: The Department will only fund abortions to save the life of the mother or in cases of rape or incest as determined by the courts. Two licensed physicians must certify in writing that the mother may die if the fetus is carried to term. This certification must contain the name and address of the recipient.